

From the Congressional Record – Senate

OCTOBER 5, 1972

Senator Gaylord Nelson (D-WI):

“There is a 20 percent copayment required for those who receive home health care under Medicare Part B...

“On the other hand, if the doctor sends an eligible patient to the hospital for 3 days and then they come back home and have home health care, there is no required copayment.

“This amendment would remove the required copayment for those under Medicare Part B. The result of this distinction is that frequently doctors feel they have to send their patient to the hospital in order to get the 3 days in, so that they will qualify for service without the copayment because they cannot afford it.

“That unnecessarily loads the hospital, and those who do not go are getting discriminatory treatment. The purpose of the amendment is to eliminate that discrimination.”

Senator Russell Long (D-LA):

“I am willing to take it to conference. Personally, I think the Senator is right.”

Why Congress Repealed the Medicare Home Health Copayment:

Coinsurance Requirement Increased Hospital Costs, Discriminated Against Patients

The Medicare Part B home health benefit originally included a 20-percent copayment to beneficiaries who received home healthcare. In 1972, Congress passed an amendment repealing coinsurance payments for home health services in Part B citing copayments as “a financial burden to many elderly persons living on marginal incomes.”

Similarly, our nation’s 3.5 million Medicare home healthcare beneficiaries are today facing the prospect of a copayment on home health services. Despite evidence that copays actually increase Medicare costs by forcing patients to seek care in costlier institutional settings, some lawmakers in Washington have suggested instituting increased fees on seniors in need of home health as a means for generating federal cost savings.

The same reasons exist today for rejecting cost-sharing for Medicare home health patients that existed in 1972:

REASONS NOT TO REIMPOSE A HH COPAY	SUPPORTIVE DATA
Low-income beneficiaries are disadvantaged and unable to afford out-of-pocket copayments.	The average annual cost of living for low-income beneficiaries is \$15,648 ¹ . Data suggest that as much as one-third of a senior’s income, after Medicare Part B premium costs and living expenses, would be put towards increased out-of-pocket fees.
Patients would forgo physician-prescribed home health to avoid the copayment and end up receiving care in more expensive institutional settings.	A study in the New England Journal of Medicine ² found that copays resulted in 2.2 percent more annual hospital admissions and 13.4 more inpatient days per plan enrollee. Therefore, the cost of additional hospitalizations exceeded savings.
The cost of providing skilled home health services is far less than care in traditional care settings.	The average Medicare payment for a hospital stay of a few days is \$10,000 versus \$3,000 for a typical home health episode (covers 60 days).

MedPAC: Copay Directly Impacts Beneficiaries

In their March 2013 Report to the Congress, MedPAC states:

“The growth in healthcare spending has a direct and meaningful impact on individuals and families. Evidence shows that growth in out of pocket spending has negated real income growth in the past decade. In addition, the lasting effects of the economic downturn affected the income, insurance status, and assets (namely the value of owned homes) of many people, including Medicare beneficiaries and those aging into Medicare eligibility. Likewise, cost sharing and premiums for Medicare beneficiaries are projected to grow faster than Social Security benefits.”

1. Avalere analysis of the 2010 Bureau of Labor Statistics Consumer Expenditure Survey for all households with at least one individual age 65 or older and annual income below 200% of the Federal Poverty Limit.

2. Trivedi, Amal N., Husein Moloo and Vincent Mor. “Increased Ambulatory Care Copayments and Increased Hospitalization among the Elderly.” New England Journal of Medicine 362 (2010): 320-328.